MISSOURI

DIVISION OF MEDICAL SERVICES

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SPECIAL BULLETIN
(RETRO-ELIGIBILITY UPDATE)

Provider Bulletin News: Due to budget constraints, paper copies of bulletins will no longer be distributed by DMS. Bulletins are now available only at the DMS Website. http://www.dss.mo.gov/dms/pages/bulletins.htm Please note new website address.

Bulletins will remain on this site only until incorporated into the provider manuals as appropriate, then deleted.

Missouri Medicaid News: Missouri Medicaid providers may sign-up to receive automatic notifications of all bulletins and other official Missouri Medicaid communications via e-mail. Providers and other interested parties are urged to go to the DMS website to subscribe to the e-mail list.

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MC+ MANAGED CARE

The information contained in this bulletin applies to coverage by the MC+ fee-for-service and Medicaid fee-for-service programs. The MC+ fee-for-service and Medicaid fee-for-service programs also provide coverage for those services carved out of the MC+ Managed Care benefit for MC+ Managed Care enrollees. Questions regarding services included in the MC+ Managed Care benefit should be directed to the enrollee's MC+ Managed Care health plan. Please check the patient's eligibility status prior to delivering a service.

UPDATE OF EXCEPTIONS TO THE PRIOR AUTHORIZATION REQUIREMENT

Effective immediately, an approval letter from the Family Support Division reflecting eligibility dates is no longer required to process a claim for retro-eligibility for a service that requires prior authorization.

Section 8.4 of all manuals, regarding retroactive eligibility, will be changed to read:

The recipient was not eligible for Medicaid at the time of service, but eligibility was made retroactive to that time. If the provider is unable to obtain an eligibility approval letter from the recipient, the claim may be submitted with a completed Certificate of Medical Necessity form indicating the recipient was not eligible at the time of service but has become eligible retroactively to that date. The provider must also indicate on the Certificate of Medical Necessity form, in detail, the reason for the provision of service (See Section 7 in the provider manual for information on completing the Certificate of Medical Necessity form). If the eligibility approval letter or the Certificate of Medical Necessity form is not submitted or the reason does not substantiate the provision of the service, the claim will be denied.

For other exceptions to the prior authorization requirement, see Section 8 in the provider manual at the DMS Website. http://www.medicaid.state.mo.us/

UPDATE OF EXCEPTIONS TO THE SECOND SURGICAL OPINION REQUIREMENT

Please note, an approval letter from the Family Support Division reflecting eligibility dates is no longer required to process a claim for retro-eligibility for a service that requires a second surgical opinion.

The following exceptions to the second opinion requirement are effective immediately:

- The Second Surgical Opinion Form is not required if the surgeon does not participate in the Missouri Medicaid Program. The provider must submit a claim and a Certificate of Medical Necessity form and indicate on the medical necessity form the surgeon's full name and indicate "non-participating".

- If the service was performed as an emergency and a second opinion could not be obtained prior to rendering the service, submit a claim and a Certificate of Medical Necessity form indicating the reason for the emergency provision of service.

- The recipient was not eligible for Medicaid at the time of service, but was made retroactive to that time. If the provider is unable to obtain an eligibility approval letter from the recipient, the claim may be submitted with a completed Certificate of Medical Necessity form indicating the recipient was not eligible at the time of service but has become eligible retroactively to that date. (See Section 7 in the provider manual for information on completing the Certificate of Medical Necessity form). If the eligibility approval letter or the Certificate of Medical Necessity form is not submitted, the claim will be denied.

For other exceptions to the second opinion requirement, see Section 13.30.E in the Physician's Provider Manual at the DMS Website. http://www.medicaid.state.mo.us/

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